# Data Sources

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*Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2002 Report* contains information and data from a variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regards to methodology, sampling and collection procedures, as well as reliability and validity of the data. Readers are encouraged to consult the original data sources for more detailed information. Additional organizations are presented to provide the reader with a variety of other resources. When available, websites are provided.

## *National Sources*

**Monitoring the Future** (http://www.isr.umich.edu/src/mtf/)

The Monitoring the Future study is conducted by the Institute for Social Research, University of Michigan and supported by research grants from the National Institute on Drug Abuse. The Monitoring the Future project, begun in 1975, has many purposes. Among them is to study changes in the beliefs, attitudes, and behavior of young people in the United States. Changes in public attitudes and behavior are often first seen among youth. The results of the study are useful to policy makers at all levels of government. Data are used to monitor progress toward Goal 7 (Safe, Disciplined, and Alcohol and Drug-Free Schools) of the Goals 2000 National Education Goals, as well as toward national health objectives. Study results are also used to monitor trends in substance use and abuse among adolescents and your adults, and are used in the development of the White House National Drug Control Strategy.

**National Institute on Alcohol Abuse and Alcoholism (NIAAA)** (http://www.niaaa.nih.gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems by:

- Conducting and supporting research directed at determining the causes of alcoholism, discovering how alcohol damages the organs of the body, and developing prevention and treatment strategies for application in the health care system;
- Supporting and conducting research across a wide range of scientific areas including genetics, neurosciences, medical consequences, medication development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program;
- Conducting policy studies that have broad implications for alcohol problem prevention, treatment, and rehabilitation activities;
- Conducting epidemiological studies such as national and community surveys to assess risks for and magnitude of alcohol-related problems among various population groups;
- Collaborating with other research institutes and federal programs relevant to alcohol abuse and alcoholism, and providing coordination for federal alcohol abuse and alcoholism research activities;

# Data Sources

- Maintaining continuing relationships with institutions and professional associations; with international, national, state and local officials; and voluntary agencies and organizations engaged in alcohol-related work; and
- Disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIH is a component of the Public Health Service within the U.S. Department of Health and Human Services.

**Bureau of Justice Statistics** (http://www.ojp.usdoj.gov/bjs/)

The Bureau of Justice Statistics (BJS), a component of the Office of Justice Programs in the U.S. Department of Justice, is the United States' primary source for criminal justice statistics. BJS collects, analyzes, publishes, and disseminates information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government. These data are critical to federal, state, and local policymakers in combating crime and ensuring that justice is both efficient and evenhanded.

Annually, BJS publishes a document that presents findings of major BJS statistical series, describes BJS data collection programs, and summarizes programs to help States and localities to develop automated information systems. The most recent edition is *Bureau of Justice Statistics 2000: At a Glance*. The information in this report is also available from the BJS web site at http://www.ojp.usdoj.gov/bjs/abstract/bjas00.htm.

**Federal Bureau of Investigation – Uniform Crime Reports** (http://www.fbi/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from alomst 17,000 state and local law enforcement agencies, covering almost 95% of the nation's population. Data are gathered by state and local agencies and submitted to the FBI, in most cases through state UCR offices. Reliability and completeness of data are the responsibility of the submitting agencies. The FBI monitors each submitted report, and significant increases or decreases in rates are subject to special inquiry by UCR staff.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reporting levels may vary according to a wide variety of factors, including community, funding, and aggressiveness of local law enforcement agencies. Another system, the National Crime Victimization Survey, collects data on unreported as well as reported crime by surveying a representative sample of households.

In Washington State, UCR reports produced by the Washington Association of Sheriffs and Police Chiefs and which is the source for FBI state data, do not include data from the Seattle Police Department (SPD). SPD does not collect their statistics in a manner that is compatible with UCR. Crime indicators in this *Report* do not include data from Seattle.

# Data Sources

**Centers for Disease Control and Prevention** (http://www.cdc.gov/)

The federal Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of Americans, for providing credible information to enhance health decisions, and for promoting health through strong partnerships. Headquartered in Atlanta, CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers. CDC is one of eight federal public health agencies within the U.S. Department of Health and Human Services.

**National Center for Injury Prevention and Control** (http://www.cdc.gov/ncipc/index.htm)

The National Center for Injury Prevention and Control works to reduce morbidity, disability, mortality, and costs associated with injuries.

**HIV/AIDS Surveillance Report** (http://www.cdc.gov/hiv/stats/hasrlink.htm)

The HIV/AIDS Surveillance Report is published semi-annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. It contains tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category.

**National Center for HIV, STD and TB Prevention – Division of Sexually Transmitted Diseases** (http://www.cdc.gov/nchstp/dstd/Stats_Trends/Stats_and_Trends.htm)

The Division of STD Prevention at the Centers for Disease Control and Prevention provides national leadership through research, policy development, and support of effective services to prevent sexually transmitted diseases (including HIV infection) and their complications such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancer. The Division assists health departments, health-care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development of national goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

**National Center for HIV, STD and TB Prevention – Division of Tuberculosis Elimination** (http://www.cdc.gov/nchstp/tb/surv/surv.htm)

The TB Surveillance Reports are published annually by the Division of TB Elimination, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention. They contain tabular and graphic information about reported TB cases collected from 59 reporting areas (the 50 states, the District of Columbia, New York City, U.S. dependencies and possessions, and independent nations in free association with the United States). The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistics areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc).

# Data Sources

**Behavioral Risk Factor Surveillance System** (http://www.cdc.gov/nccdphp/brfss/)

The Behavioral Risk Factor Surveillance System (BRFSS), administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, is an on-going data collection program. By the early 1980s, scientific research clearly showed that personal health behaviors played a major role in premature morbidity and mortality. Although national estimates of health risk behaviors among U.S. adult populations had been periodically obtained through surveys conducted by the National Center for Health Statistics, these data were not available on a state-specific basis. This deficiency was viewed as critical for state health agencies that have the primary role of targeting resources to reduce behavioral risks and their consequent morbidity. National data may not be appropriate for any given state; however, state and local agency participation is critical to achieving national health objectives.

About the same time as personal health behaviors received wider recognition in relation to chronic disease morbidity and morality, telephone surveys emerged as an acceptable method for determining the prevalence of many health-risk behaviors among populations. In addition to cost advantages, telephone surveys were specially desirable at the state and local level, where the necessary expertise and resources for conducting area probability sampling for in-person household interviews were not likely to be available.

As a result, surveys were developed and conducted to monitor state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality. The basic philosophy was to collect data on actual behaviors, rather than on attitudes or knowledge, which would be especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs. Although the BRFSS was designed to collect state-level data, a number of states from the outset stratified their samples to allow them to estimate prevalence for regions within their respective states. By 1994, all states, the District of Columbia, and three territories were participating in the BRFSS.

**National Center for Health Statistics** (http://www.cdc.gov/nchs/)

The mission of the National Center for Health Statistics (NCHS) is to provide statistical information that will guide actions and policies to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. Some NCHS data systems and surveys are ongoing annual systems while others are conducted periodically. NCHS has two major types of data systems: those based on populations, containing data collected through personal interviews of examinations; and those based on records, containing data collected from vital and medical records.

**National Highway Traffic Safety Administration – Fatality Analysis Reporting System** (http://www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) was developed in 1995 to facilitate collection and reporting of data for all fatal crashes involving automobiles in the United States, and to provide a basis for evaluating overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Each state in turn locates appropriate source documents from which fatal crash information is extracted.

# Data Sources

## *State Sources*

**Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET**

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

**Office of Financial Management – Population Trends for Washington State** (http://www.ofm.wa.gov)

The Office of Financial management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

**Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis – Washington Needs Assessment Household Survey** (http://psy.utmb.edu)

The Washington Needs Assessment Household Survey (WANAHS) was a statewide survey of over 7,000 adults designed to measure the prevalence of substance use and need for treatment. The survey was conducted over a 14-month period from September 1993 through October 1994. The WANAHS sample included large number of minorities and other groups in order to facilitate demographic analysis. Several statewide and county-level profiles have been prepared based on WANAHS, the most recent being *Profile of Substance Use and Need for Treatment in Washington State* (1999).

**Washington State Department of Health – Center for Health Statistics** (http://www.doh.wa.gov/)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Data for Washington State Vital Statistics are compiled for each year from certificates received before April 15 of the following year.

**Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System**

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.

# Data Sources

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

**Washington Traffic Safety Commission** (http://www.wa.gov/wtsc/index.htm)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitates these efforts in Washington State since 1967. Governor Gary Locke serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

**Washington State Survey of Adolescent Health Behaviors.**

The Washington State Survey of Adolescent Health Behaviors (WSSAHB) provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of the Superintendent of Public Instruction (OSPI). The WSSAHB includes a sample of public schools students in grades 6, 8, 10, and 12. The survey provides information on tobacco, alcohol and other drug use, violence, related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- Students survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2000), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.